Kentucky Diabetes Connection

The Communication Tool for Kentucky Diabetes News

AACE
American Association of Clinical Endocrinologists Ohio Valley Chapter

ADA
American Diabetes Association

DECA
Diabetes Educators Cincinnati Area

GLADE
Greater Louisville Association of Diabetes Educators

JDRF
Juvenile Diabetes Research Foundation International

KADE
Kentucky Association of Diabetes Educators

KEC
Kentuckiana Endocrine Club

KDN
Kentucky Diabetes Network, Inc.

KDPCP
Kentucky Diabetes Prevention and Control Program

TRADE
Tri-State Association of Diabetes Educators

A Message from Kentucky Diabetes Partners

This premier issue of the *"Kentucky Diabetes Connection"* is a new creation of Kentucky Diabetes Partners working collectively for a common goal… *IMPROVING DIABETES CARE AND EDUCATION FOR KENTUCKIANS WITH OR AT RISK FOR DIABETES!!* This newsletter will offer education, sharing, networking, and advocacy between Kentucky entities that impact diabetes. Ultimately, it is hoped that the people touched by diabetes in Kentucky will be better served!

Ideas for what to include within this new communication tool, as well as who should receive this newsletter, will be ever-changing. We hope you enjoy this first issue, and even more than that, we hope you embrace this statewide newsletter by offering your ideas and assistance to make this new tool everything you need it to be!

Inside this first issue, you will find numerous articles written by professionals from various diabetes partners. The *KY Diabetes Connection* will be printed quarterly – so feel free to offer articles for inclusion. This is only the beginning of what we can accomplish together when working for diabetes! For more information, contact Janice Haile at (270) 686-7747 x 5562 or janice.haile@grdhd.org.

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ARE YOU READY FOR A NEW CLASS OF AGENTS FOR TREATING DIABETES?

Submitted By: Vasti Broadstone MD, Endocrinologist
AACE Ohio Valley Chapter & Kentuckiana Endocrine Club

Brace yourselves for an influx of new agents for the management of diabetes, some already on file at the FDA, because here they come! These new agents are the gut hormones, more specifically, Glucagon- Like Peptides (GLP-1). These agents increase insulin secretion, improve Beta (B) cell function, and promote weight loss. Too good to be true? The catch: it is injectable, BID SQ, and cannot be mixed with insulin. However, long – acting release formulation is in early development for a once -a- month injection.

The Incretin Effect

In non - diabetic subjects, insulin response to oral administration of glucose is greater than to IV administration. This is due to secretion of incretins, GIP (Gastric Inhibitory Polypeptide) and GLP-1 by the intestinal L- cells in the ileal mucosa. Thus, the "incretin effect".

Mechanism of Action

GLP-1 action is mediated by its binding to a cell surface receptor. GLP-1 receptors (GLP-1- R) are highly expressed on the cell membranes of pancreatic B cells and the lung. The binding is very specific and through the activation of the adenylyl cyclase pathway, it causes glucose – dependent insulin secretion. Because the insulin secretory action of GLP-1 is regulated by the plasma concentration of glucose, it does not cause hypoglycemia.

GLP-1 regulates the concentration of glucose in the plasma by mechanisms other than stimulating secretion. These mechanisms include the inhibition of gastric motility and the inhibition of glucagon secretion; therefore, hepatic glucose production is also inhibited.

Individuals with type 2 diabetes have decreased GLP-1 levels. However, unlike GIP, the glucose- lowering actions of exogenously administered GLP-1 remains preserved in patients with type 2 diabetes.

B cell preservation

Exposure to GLP-1 has proliferative effects on islet cells in rodent and human in vitro studies. In the great majority of animal models with and without diabetes, the use of GLP-1 or its agonists results in B cell proliferation , islet neogenesis , and expansion of functional B cell mass . They also inhibit B cell death by apoptosis. Ongoing studies will test whether GLP-1 administration enhances the viability of B cells in islet transplantation.

Six weeks of continuous sub-cutaneous GLP-1 infusion in type 2 diabetes patients over the age of 40 with a mean HbA1C of 9% resulted in improvement in fasting glucose and HbA1C. Furthermore, there was improvement in C-peptide responses to glucose and arginine, suggesting improvement in B-cell function.

Weight loss

The GLP-1 receptors located in the hypothalamus have been shown to have an effect on satiety. Studies in animal models as well as humans (including overweight and type 2 diabetes individuals) with IV infusion of GLP-1 increase satiety and decrease caloric intake.

GLP-1 analogues

GLP-1 has a very short half-life (minutes), because it is readily degraded by the DPP IV enzyme (dipeptidyl peptidase IV). Although IV or SQ infusion of GLP-1 is effective, it is not a viable option for everyday practice.

Exendin-4 is a peptide isolated from the saliva of the Gila monster lizard. Exendin-4 has affinity for the GLP-1 receptor, but has a much longer half-life, because it is resistant to degradation by DPP-IV. A synthetic Exendin-4, Exenatide , is awaiting FDA approval and will be marketed by Amylin and Lilly under a trade name. The most common side effect is nausea.

Another analogue now in phase 3 studies is liraglutide. It is produced by Novo-Nordisk.

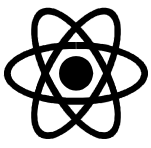
DPP-IV blockers

DPP-IV blockers are under development in oral formulation. However, the greatest limitation of DPP-IV inhibitors is that non-specific inhibition may result in increased levels of other hormones similarly cleaved by DPP-IV, such as neuropeptide Y, endorphin, growth hormone- releasing hormone, and other chemokines. DPP-IV is also found on the surface of T-cells. This raises the possibility that DPP-IV inhibition may compromise immune function. Recent reports show this may not be the case. Nevertheless, selective inhibition agents are being explored.

Conclusion

The unique biological features of GLP-1 make this peptide hormone an ideal candidate for the treatment of diabetes. Many of the compounds in the pipeline are first-in-class compounds that would target physiologic defects not addressed by the currently available medications for type 2 diabetes. These agents have the potential to be complementary in action to the current agents. By improving B-cell sensitivity to glucose and promoting B-cell regeneration, these compounds may have a role in protecting the B-cell from inevitable decline. Therefore, they offer the possibility of changing the natural history of type 2 diabetes in clinical practice.

References Available Upon Request



DID YOU KNOW YOU CAN HAVE FREE HEALTH AND KIDNEY SCREENINGS OFFERED TO YOUR DIABETES PATIENTS?

As a Kentucky physician or diabetes educator dealing with patients who are at high risk for kidney disease, you will be interested in knowing how you can set up free lifesaving screening tests for your patients 18 years or older who have diabetes or high blood pressure! The National Kidney Foundation (NKF) of Kentucky through the Kidney Early Evaluation Program (KEEP) will provide free health screening programs for individuals at increased risk of developing kidney disease!

The free screening tests provided to high risk patients 18 years of age or older include: blood pressure, weight, blood glucose, hemoglobin, urine dipstick (for protein, microalbumin, hematuria and pyuria), serum creatinine, albumin to creatinine ratio and calculated creatinine clearance. In addition, individuals 18 years and older who have a parent, grandparent, brother, or sister with diabetes, high blood pressure, or kidney disease are also eligible to participate! This program also offers free counseling and referral.

More than 90% of the 35,000 patients in 49 states, who have participated in these free screenings, have had one or more of the test results at sub-optimal values. Fifty percent of participants were identified with chronic kidney disease (CKD), yet only 3% knew prior to the testing, that they were at risk. Nearly 3/4 of KEEP participants reported having diabetes or a family history of diabetes and 63 to 83% were classified as overweight, obese or extremely obese.

The goals of KEEP are to:

- Raise awareness about kidney disease especially among "high risk" individuals.
- Provide free testing for people at increased risk for kidney disease.
- Encourage people "at risk" to visit a doctor and follow the treatment plan recommended.
- Provide educational information so that "at risk" individuals can prevent or delay kidney damage.
- Provide doctor referrals for follow-up care, if needed.
- Provide ongoing information and support.

To obtain more information about how to set up free screenings for your diabetes patients and their family members, contact Lisa Allgood at the National Kidney Foundation of Kentucky at 1-800-737-5433 or (502) 585-5433, email lallgood@nkfk.org. To find out more information about the KEEP program, visit www.KEEPonline.org.

Please call to set up a FREE KIDNEY SCREENING within your practice today!!

AMERICAN DIABETES ASSOCIATION ANNOUNCES DIABETES RESEARCH GRANT TO THE UNIVERSITY OF KENTUCKY

Submitted by: Larry Smith, Chair-Elect National ADA Board of Directors and Stewart Perry, Chair National ADA Advocacy Committee

An American Diabetes Association (ADA) research grant of $400,000 was given to the University of Kentucky for diabetes research. This grant of $400,000 brings the total amount of money currently committed to UK to over $2,000,000 and the total for the state of Kentucky to over $3,280,000. The American Diabetes Association is proud of its accomplishments in Kentucky and pleased to return more dollars than raised to fund programs, advocacy and research efforts in the state. This demonstrates ADA's commitment to the people with diabetes in Kentucky, which is defined by the ADA's mission statement "To Prevent and Cure Diabetes and to improve the Lives of All People Affected by Diabetes".

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DR. WILLIAM HACKER APPOINTED PUBLIC HEALTH COMMISSIONER

Dr. William Hacker has been appointed Commissioner of the Department for Public Health (DPH), following a nationwide search. Dr. Hacker has served as acting Commissioner for the Department since July 2004.

Dr. Hacker joined the Department for Public Health as a Physician Consultant in 2001. He has served as the Branch Manager for the Public Health Preparedness Branch since 2002, where he headed up the Department's disaster preparedness planning efforts, funded by grants from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). He is also currently the Acting Director of the Division of Laboratory Services and the Acting Manager of the Chemistry Branch in the Division of Laboratory Services within DPH.

Prior to joining state government, Dr. Hacker's experience included almost 20 years of private medical practice, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. He is a native of Manchester, Kentucky, and received both undergraduate and medical degrees from the University of Kentucky.

KENTUCKY WELL REPRESENTED AT THE AMERICAN ASSOCIATION OF DIABETES EDUCATORS (AADE) ANNUAL MEETING IN INDIANAPOLIS!

Kentucky was well represented at the American Association of Diabetes Educators (AADE) annual meeting held in Indianapolis this past August! Nearly 200 Kentucky Diabetes Educators traveled to Indy to take part in the largest annual meeting ever held!

This year's conference, chaired by our own Patty Geil, MS, RD, CDE from Lexington, KY, set a record for the largest overall attendance (6400 total attendees with 3700 paid diabetes educators), the greatest number of educational offerings, and largest number of exhibitors (at 200)!!

Other Kentucky Notables at the Annual AADE Meeting….

Kim DeCoste MSN, RN, CDE from Richmond KY presented, "Innovation in Caring for Diabetes: Emerging Treatment Options" and "Driving Into the Future: Steering for Successful Chapter Leadership".

Carolyn Dennis MS, RD from Lexington, KY presented, "Joining Hands Instead of Pointing Fingers: Building Coalitions to Fight the Childhood Obesity Epidemic".

Deborah Fillman MS, RD, CDE from Owensboro, KY served on the national AADE Board of Directors in 2004 and for the past several years.

Patty Geil, MS, RD, CDE from Lexington, KY (with Laura Hieronymous) presented, "Type 2 Diabetes and Pregnancy: Unique Challenges for the Diabetes Educator".

Laura Hatcher BSN, RN, CDE from Burlington, KY presented, "Insulin Therapy Choices: Putting Patients and Families in the Driver's Seat".

Laura Hieronymous MSEd, APRN, CDE from Lexington, KY presented, "Got Diabetes: Laugh for the Health of It" and (with Patty Geil) "Type 2 Diabetes and Pregnancy: Unique Challenges for the Diabetes Educator".

Kathleen Stanley RD, LD, MSEd, CDE from Lexington, KY presented, "Creative Ways to Generate Revenue for a Diabetes Education Department" and "A Primer on Developing Office and Community Based Pre-Diabetes Programs".

Raymond Reynolds MD, Endocrinologist from Lexington, KY presented, "Impact of Lifestyle Change in Metabolic Outcomes and Estimated Cost Savings".

In addition, numerous KY AADE members served as monitors and or moderators for several of the educational sessions. The four KY chapters of AADE (DECA, GLADE, KADE, and TRADE) were also represented at the Presidents Chapter Council meeting.

Last but not least, **Melanie Perry MS, RD, LD, CDE** from Lexington, KY and the Kentucky Diabetes Prevention and Control Program (KDPCP) were honored to receive the Allene Von Son Diabetes Educator Award (category II printed educational tools) for the KDPCP PowerPoint curriculum / slide program regarding "Diabetes in Kentucky and Pre-diabetes Prevention".

CONGRATULATIONS TO ALL KENTUCKY DIABETES EDUCATORS WHO ARE IMPACTING DIABETES CARE IN OUR STATE AND NATION!!

FREE EDUCATIONAL ITEMS OFFERED BY NATIONAL DIABETES EDUCATION PROGRAM

Submitted by: Linda Leber, RN, BSN, CDE
KDPCP State Staff

The National Diabetes Education Program (NDEP) recently released 3 new resources for health care professionals.

1. ***Working Together to Manage Diabetes: A Guide for Pharmacists, Podiatrists, Optometrists, and Dental Professionals,*** is an interdisciplinary primer that focuses on diabetes-related conditions that affect the foot, eye, and mouth, as well as issues related to drug therapy management. The booklet promotes a team approach to comprehensive diabetes care and provides simple care recommendations to providers in making cross-disciplinary treatment referrals.

2. An interdisciplinary color poster, ***Working Together to Manage Diabetes,*** can be used by health care professionals in exam or waiting rooms to help educate patients about the importance of controlling the ABCs (A1c, Blood Pressure, and Cholesterol) of diabetes. It also lists specific actions that patients can take with their eye, foot, dental professionals and pharmacists to control diabetes.

3. ***Working Together to Manage Diabetes: Diabetes Medications Supplement,*** is a reference booklet that provides a profile of diabetes medications, including insulin, oral agents, and medications to lower high blood pressure and treat high cholesterol. Single copies of each resource are free and can be obtained by calling the National Diabetes Information Clearinghouse at 1-800-438-5383 or electronic versions can be downloaded from the NDEP website at www.ndep.nih.gov.

DIABETES AND SLEEP DEPRIVATION: WHAT THE DIABETES EDUCATOR SHOULD KNOW

Submitted by: Kathryn Hansen,
Executive Director Kentucky Sleep Society

Did you know that sleep deprivation can be as harmful to a person's health as a poor diet or limited exercise! **Chronic sleep loss has been linked to serious health problems** including untreated sleep apnea, restless leg syndrome, high blood pressure, **diabetes**, and being overweight.

An important function of sleep is to assist with glucose metabolism. Sleep deprivation prompts the body to create excess insulin, which can lead to insulin resistance, a risk factor for Type 2 diabetes. Excess insulin also promotes the storage of body fat, linking it to high blood pressure and being overweight.

Sleep apnea occurs when the upper airway repeatedly collapses causing cessation of breathing (apnea) and sleep fragmentation. Sleep fragmentation results in chronic daytime sleepiness. The number of apneic episodes per hour of sleep are indicative of acuity. These episodes may range from 25-60 times per hour of sleep and may last from 10 seconds to several minutes in duration. Oxygen desaturation associated with most of these apneic events contributes to diabetes, obesity, hypertension, cardiac arrythmias, myocardial ischemia, myocardial infarction, stroke, motor vehicle accidents, work-related accidents, decreased quality of life and increased use of health care resources.

Do your patients with diabetes have symptoms of sleep apnea?

- **Gasping or choking during sleep**
- **High Blood Pressure**
- **Diabetes**
- **BMI > 30**
- **Excessive daytime sleepiness**
- **Loud habitual snoring**
- **Poor concentration and memory**
- **Irritability**

If your patients have at a minimum, a BMI > 30 and hypertension or diabetes with daytime sleepiness, a consultation by a sleep specialist is recommended.
Abstinence from alcohol and avoiding sedating drugs is recommended since they may exacerbate sleep apnea and worsen daytime sleepiness.

A co-variant of sleep apnea is the presence of restless legs or periodic limb movements. Rhythmic intermittent leg or arm jerks cause interruption in the continuity of sleep, leading to an accumulated sleep debt.

The lack of adequate sleep creates a health risk. Seeking treatment for sleep disorders facilitates improved management of diabetes, heart disease and obesity.

For more information, contact the Kentucky Sleep Society at 859.252.6447 or www.kyss.org

KENTUCKY DIABETES PREVENTION & CONTROL PROGRAM (KDPCP) TO BE HIGHLIGHTED IN CDC ANNUAL PUBLICATION

Minnesota, Kentucky, California, Utah, and New York's Diabetes Prevention & Control Programs were selected to be highlighted in the Centers for Disease Control (CDC) annual Diabetes Program Review Book. According to Sharon Morris, CDC Public Health Analyst, successful states were selected by Dera Murphy, Branch Chief of the CDC Diabetes Program Development Branch. The book is to be published in 2005.

CONGRATULATIONS KENTUCKY!

FREE BLOOD PRESSURE MONITORS OFFERED FOR PATIENT TESTING!

Want to better educate your diabetes patients about monitoring their blood pressure? To help you keep your patients in the best of health, Omron is OFFERING free blood pressure monitors to health professionals. To receive your free Blood Pressure Monitor, simply visit www.omronhealthcare.com and register as a "Medical Professional". After you have registered, you will have access to the application for the Professional Sampling Program. Once you have downloaded the application, fill it out and submit it to Omron via U.S. mail. Upon receiving your request, Omron will send you the following items:

- 1 IntelliSense Automatic Blood Pressure Monitor for use in patient teaching.
- 50 "Blood Pressure 101" brochures in an attractive display.
- 50 coupons worth $5.00 off any Omron IntelliSense Blood Pressure Monitor.

HEART ATTACK-- AN INFECTIOUS DISEASE?

Submitted by: Mary Linda Rogers, MS, CN, CDE
TRADE Member

"I have seen the future and it works, but not without YOUR help." According to Dr. Peter Salgo, "we are now in a position to offer persons with diabetes an end to the epidemic of premature death due to heart attack." These were the first 2 sentences in the American Association of Diabetes Educators (AADE) *31st Annual Program Book.* The speaker was Peter L. Salgo, MD, of New York Presbyterian Hospital and Columbia University College of Physicians and Surgeons in New York, NY.

According to Dr. Salgo, 50% of heart cathorizations show no significant plaque! He proceeded to describe 2 kinds of plaque. One is hard plaque that causes angina but does not cause myocardial infarction (MI). The second is soft plaque that contains high concentrations of LDL. So why do some people suffer MI and others not? His explanation is that within the arterial walls of the person who suffers a MI lives a strain of Chlamydia. The Chlamydia organisms were formerly considered to be viruses, but are, in fact, bacteria.

If you are like me, when I think of Chlamydia, I think of sexually transmitted disease; but in fact there are different species of the genus Chlamydia. The newly designated species that is associated with risk for MI is Chlamydia pneumoniae. According to an article by Aristo Vojdani, "Chlamydia pneumoniae is less famous than its cousins which cause sexually transmitted disease (C. trachomatis) or conjunctivitis (C. psittaci), but it is far more widespread and may be far more dangerous."

The article by Aristo Vojdani states that, "We will all encounter this bacterium sooner or later, most of us more than once. It is commonly spread through coughs and sneezes, causing a flu-like respiratory condition that sometimes progresses to pneumonia. High proportions of adults from different countries are positive for antibodies to C. pneumoniae, implying a high prevalence of these infections. Several lines of evidence suggest that Chlamydia pneumoniae can make its way into the walls of various blood vessels, linger for years inducing the inflammation and immune reaction that causes heart attacks and strokes. This does not imply that C. pneumoniae infection is the sole cause of atherosclerosis, or that diet and exercise do not matter. But mounting evidence suggests that the leading cause of death in the western world is to some degree contagious and that common antibiotics might help bring it under control!"

Keeping this in mind, Dr. Salgo, proceeded to explain that heart attack, is actually an infectious disease! I was mesmerized by the remainder of his talk as he proceeded to describe how this bacteria causes plaque and because bacteria must eat to thrive, ways to decrease their food supply within the arterial walls.

Dr. Salgo relayed that statin drugs work to decrease 80% of cholesterol made by the body. He further suggested that the current recommendation of LDL < 100 is not in line with significant decreases in risk, but that data suggests an LDL level of <70 is best. In order to decrease LDL to that level, most people would have to be on a statin. He proceeded to recommend anti-inflammatory drugs NOT steroids, but NSAIDS as best in lowering the inflammation. He labeled aspirin as the "Swiss Knife of Drugs" and recommends a daily baby aspirin. He added that there is an association with high iron stores in MI victims due to the fact that the Chlamydia pneumoniae also likes iron.

For further information, see the references listed below. In the meantime, have you had your aspirin and Lipitor today?

Dr. Salgo's presentation was taped and can be purchased from AADE (www.diabeteseducator.org). The presentation title was "*Sugar-Coated Future: Problem or Opportunity"*. To view the article by Aristo Vojdani,visit www.cfsresearch.org/chlamydia/linkschronic/5nf.htm

PATHS TO A DIABETES CURE THROUGH THE JUVENILE DIABETES RESEARCH FOUNDATION

Submitted by: Twynette Davidson
Executive Director JDRF Kentuckiana Chapter

In the next five years, some $2.5 billion will be spent on type 1 diabetes research around the world. This 2.5 billion includes projected Juvenile Diabetes Research Foundation International (JDRF) funds of $500 million, industry investment, and a $750 million supplement from the U.S. National Institutes of Health, (passed as a result of JDRF advocacy).

JDRF will play a unique role in setting the global direction of these research resources, to ensure that they are used as effectively as possible to bring about a world without juvenile diabetes and its complications.

To that end, Juvenile Diabetes Research Foundation International will focus on six therapeutic targets for the next five years:

1. Perfecting islet transplantation - without chronic immunosuppression - to permanently restore normal blood sugar levels in people with type 1 diabetes
2. Creating safe, stable, and widely available "universal donor" sources of insulin-secreting cells for transplantation-through stem cell research and research to develop safe, human-compatible islet cells from animal sources
3. Regenerating the body's own beta cells without islet transplantation - and simultaneously inducing immune tolerance to restore normal blood sugar levels
4. Perfecting a closed-loop artificial pancreas
5. Creating novel approaches and therapeutics for predicting, preventing and reversing complications
6. Preventing type 1 diabetes by maintaining or restoring immune tolerance in new-onset patients.

Juvenile Diabetes Research Foundation International is the largest non-profit, non-government funder of diabetes research in the world. For information, visit **www.jdrf.org**

THE AMERICAN DIABETES ASSOCIATION A PROUD PART OF KENTUCKY'S DIABETES COMMUNITY

Submitted by: Francine Haddad,
ADA, National Advocacy Field Director

The American Diabetes Association (ADA) is a proud member of the Kentucky Diabetes Network (KDN) and an integral part of the diabetes community in Kentucky. The missions of ADA and KDN are very similar, which has allowed a strong collaboration to develop in recent years.

This is particularly true in the case of advocacy. Diabetes advocacy in Kentucky has been greatly enhanced during the past few years as ADA and KDN have worked together strengthening their alliance and increasing diabetes awareness among policy makers at the capitol in Frankfort. This alliance also encompasses other parts of the Kentucky diabetes community including the Kentucky Diabetes Prevention and Control Program, health care professionals such as endocrinologists, ophthalmologists, podiatrists, nephrologists, as well as diabetes educators including nurses, dietitians, pharmacists and physicians assistants. And last, but not least, this alliance includes people living with diabetes.

A longstanding goal of the KY diabetes community is to increase diabetes funding (in Kentucky). Diabetes state funding has never been increased from its original appropriation (in the late 1970's) of $1.4 million. ADA supports increasing the diabetes appropriation in Kentucky and has been pleased to work with KDN on this effort. ADA has advocated on the KY Diabetes funding issue are by participating in meetings with Governor Fletcher and legislative leadership, conducting advocacy training as part of the KDN Legislative Day at the Capitol, and providing materials for advocates/legislators. Kentucky, like most other states has been experiencing financial difficulties in recent years and the policy makers have not yet seen fit to increase funding for diabetes. However, as some states have reduced funding for diabetes, Kentucky has not. Although ADA will continue to seek increased funding levels for diabetes in Kentucky as part of its partnership with KDN, maintaining the diabetes budget line is a victory in itself.

ADA has been grateful for the support that KDN has provided on other diabetes legislative issues. KDN has always responded with resounding support, served as a conduit to disseminate information to other partners in the diabetes community, and ACTION! The network of people with a diabetes connection has been activated and has made a very positive impact on the legislature – and therefore on the lives of all people affected by diabetes in Kentucky.

A prime example of this joining together of forces to achieve success took place during this calendar year. Back in 1998, a law was passed in KY that required all state regulated insurance plans to provide coverage for diabetes supplies, equipment and education. Since then untold numbers of people living with diabetes in Kentucky have benefited by having access to supplies and equipment such as oral medications, insulin, syringes and blood glucose meters and strips. In addition, they have been ensured of diabetes education on how to properly use these diabetes tools as well as how to balance food and exercise, deal with sick days and all other topics related to diabetes management. This past year, that diabetes law, was threatened by an initiative to "rollback" this coverage. No less than 5 bills were introduced in the Kentucky legislature seeking to remove this much needed guaranteed coverage for people living with diabetes. The ADA turned to the KDN Board of Directors to solicit help in ensuring that the well being of Kentuckians with diabetes would not suffer. KDN and the entire KY diabetes community came through! Not only did legislators receive hundreds of contacts from their constituents via telephone, email, fax and in several cases personal visits, they actually asked ADA to "call off the dogs" because they got the message that diabetes coverage needs to exist in Kentucky! This is something that every diabetes advocate can and should be proud of! It is the best example of how citizens really do play a role in public policy when they raise their voice to be heard by the elected officials who represent them and their views in Frankfort. **However, the "rollback" issue is not gone! The diabetes community in Kentucky should know that the attempt to rollback this diabetes coverage will return again this year with a vengeance. All people connected to diabetes in Kentucky need to be prepared.** ADA will work with our diabetes partners to make sure that we share information and offer tools to help fight this "rollback" initiative.

ADA is very proud of its collaboration with the larger diabetes community in Kentucky and looks forward to continuing to work together to achieve our respective missions, and help people with diabetes.

KY DIABETES NETWORK OFFERS DIABETES AWARENESS CONTEST WITH $1000 IN PRIZES!

Submitted by: Dawn Fraze, RN, BSN, CDE
KDN and GLADE Member
Regional KDPCP Coordinator

The KY Diabetes Network (KDN) Primary Prevention Workgroup is offering a statewide diabetes awareness contest with $1000 in prizes! The contest is targeted to school age children with specific age categories & tasks and are as follows: 1st through 4th grades- drawing/painting; 5th through 8th grades- poem; 9th through 12th grades- video PSA.

Participants must convey the message of prevention of type 2 diabetes in children through healthy lifestyle choices. The complete application can be viewed at www.kentuckydiabetes.net or contact Dawn Fraze at 1-800-280-1601 or 270-769-1601 ext 129. The contest is sponsored by the KDN, Inc, Miss Indiana, 2003, and Author Linda J. Hawkins.

MEDICARE COVERAGE FOR DIABETES IN KENTUCKY

Submitted by: Lindy Lady, CMS
Center Medicare/Medicaid Services (CMS)

Did you know that the Durable Medical Equipment Regional Contractor (DMERC) for the state of Kentucky is Palmetto GBA and that they may cover the following supplies and services for diabetic patients?

Supplies Defined
Medicare covers certain supplies for people with Medicare if they have diabetes, and have Medicare Part B coverage. These covered supplies include:

- Blood sugar (glucose) monitors
- Therapeutic shoes
- Insulin pumps

Blood sugar self-testing equipment and supplies
Blood sugar (also called blood glucose) self-testing equipment and supplies are covered for all people with Medicare who have diabetes. This includes people who use insulin and people who do not use insulin.

These supplies include:

- Blood sugar monitors
- Blood sugar test strips
- Lancet devices and lancets
- Glucose control solutions for checking the accuracy of testing equipment and test strips

Medicare currently covers the same type of blood sugar testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If a person with Medicare **uses insulin,** they may receive:

- Up to 100 test strips and lancets every month, and
- One lancet device every 6 months

If a person with Medicare **does not use insulin**, they may receive:

- 100 test strips and lancets every 3 months, and
- One lancet device every 6 months

*In some cases Medicare may allow more supplies, if the physician indicates that they are medically necessary.

What is needed in order for Medicare to cover these supplies and equipment?
The following items are needed for coverage of self-testing equipment and supplies:

A prescription from the treating physician

The prescription should indicate:

- A diagnosis of diabetes
- What kind of blood sugar monitor is needed and why it is needed (i.e., if a special monitor is needed because the person with Medicare has vision problems, this must be explained by the physician)
- Whether insulin is used
- How often the blood sugar should be tested
- How many test strips and lancets will be needed for one month.

Where can the supplies and self-testing equipment be obtained?

- A pharmacy that is enrolled in the Medicare Program.
- Supplies may be ordered from a Medical Equipment Supplier that is enrolled in the Medicare Program.

Therapeutic Shoes
The types of shoes that may be covered on an annual basis are:

- One pair of depth-inlay shoes and three pairs of inserts, or
- One pair of custom-molded shoes (including inserts) if you cannot wear depth-inlay shoes because of a foot deformity, and two additional pairs of inserts.

For Medicare coverage the following conditions must be met:

- Diabetes

Have at least one of the following conditions in one or both feet:

  - Partial or complete foot amputation
  - Past foot ulcers
  - Calluses that could lead to foot ulcers
  - Nerve damage because of diabetes with signs of problems with calluses
  - Poor circulation
  - Deformed foot, and

- Treatment under a comprehensive diabetes care plan

Medicare also requires that a podiatrist or other qualified doctor:

  - Prescribe the shoes and
  - Fit or give you the shoes

Insulin Pumps and related supplies
Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare who have diabetes and who meet certain conditions.

Did you know that AdminaStar Federal, Medicare Part B covers certain services for people with Medicare that suffer from diabetes?

Diabetes self-management training
Diabetes self-management training helps people with Medicare learn how to successfully manage diabetes. This type of training must be ordered by a physician or qualified non-physician practitioner treating the beneficiary's diabetes. All DSMT programs must be accredited by the American Diabetes Association (ADA).

For a person with Medicare to qualify for diabetes self-management training they must:

- Be at risk for complications from diabetes, or
- Recently diagnosed with diabetes, or
- Already suffer from diabetes

A physician may consider a patient at risk if, during the last 12 months they have:

- Had problems controlling their blood sugar
- Changed from taking no diabetes medications to taking diabetes medication, or from oral diabetes medication to insulin
- Been diagnosed with eye disease related to diabetes
- Had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation

- Been treated in an emergency room or have stayed overnight in a hospital because of diabetes
- Been diagnosed with kidney disease related to diabetes

In order for the diabetes self-management training to be covered the following conditions must be met:

- The training must be provided from a Medicare approved diabetes education program under a plan of care prepared by a physician or qualified non-physician practitioner.
- This training must be physician ordered.

The coverage for the first year includes;

- 10 hours of initial training in 12-months.
- One of the hours may be given on a one-on-one basis.
- The other 9 hours must be in training in a group class *unless* the physician prescribes 10 hours of individual training for such conditions as blindness or deafness.
- The initial training must be completed 12 months from the time the patient first starts the training.

To be eligible for 2 more hours of follow-up training each year after the year the initial training is received, the patient must obtain another written order from the physician.

- The 2 hours of follow-up training may be with a group class or one-on-one sessions.

Some of the topics that are covered in the training include:

- General information about diabetes and treatment
- Nutrition and how to manage diet
- Managing high and low blood sugar
- Exercise and why it is important to patient's health
- How to take medications properly
- Blood sugar testing
- Foot, skin and dental care

Other Covered Services – Foot Care

Medicare may cover foot care if the patient has:

- Diabetes-related nerve damage in either foot
- One foot exam every 6 months by a podiatrist or other foot care specialist
- More frequent visits to a foot care specialist may be covered for non traumatic amputation of all or part of the foot or the foot or feet have changed in appearance that might indicate a serious foot disease

Other Covered Services – Eye Exams

People with Medicare that suffer from diabetes can get eye exams to check for diabetic eye disease.

The physician determines how often this exam may be needed.

Preventive Services - Medical Nutrition Therapy Services

In addition to diabetes self-management training, medical nutrition therapy services may also be covered for people with Medicare that suffer from diabetes or renal disease, when furnished by a registered dietitian or nutrition professional meeting certain requirements.

In order for Medicare to pay for MNT services a referral must be made by a physician.

These services can be given by a registered dietitian or nutrition professional. Services include:

- An initial nutrition and lifestyle assessment
- Nutrition counseling
- How to manage lifestyle factors that affect your diet
- Follow-up visits to check on patient progress in managing diet

Medicare may cover:

- 3 hours of one-on-one medical nutrition therapy services the first year and 2 hours each year after that.
- If the patients condition, treatment, or diagnosis changes, additional hours of medical nutrition therapy may be available.
- The physician must prescribe MNT services each year in order for Medicare to reimburse for the service(s).

Preventive Services – Glaucoma Screening

Medicare will allow people with Medicare to have their eyes check for glaucoma once every 12 months. The screening must be performed or supervised by an eye physician who is legally allowed to provide this service in the state in which it is being performed.

Non Covered Services

- Diabetes supplies and services not covered by Medicare include:
- Prescription drugs
- Insulin pens
- Insulin (unless used with an insulin pump)
- Syringes
- Alcohol swabs
- Gauze
- Orthopedic shoes
- Eye exams for glasses (called refraction)
- Routine or yearly physical exams
- Weight loss programs

The following procedure codes were effective January 1, 2003.

These two codes should be used when there is a change in the condition of the Medicare beneficiary**.**

These codes for additional hours of coverage should be used after the completion of the 3 hours of basic coverage under procedure codes 97802-97804 when a second referral is received during the same calendar year. No specific limit is set for the additional hours. (Carriers will use the dietary protocols from the ADA and the National Kidney Foundation as guides.)

G0270 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes

G0271 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

DSMT Codes

G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Go to: www.adminastar.com to obtain the 2004 FS reimbursement

INSULIN...
AND THE PERSON WITH DIABETES

Submitted by: Max Herrle RN CDE CPT
DECA Member

Actually, insulin is meant to be in everyone, but as we know, people with diabetes may not make enough insulin or it does not work very well!

Mention the word insulin, and most people think of "*out of control or bad diabetes.* " This may create thoughts of long needles and frequent, painful shots. A person may wonder what good insulin is, if they know a friend or family member suffering with kidney, eye, nerve, or cardiac disease despite the insulin injections. However, with the ongoing advancements in diabetes care, these types of problems can be delayed or prevented. Today, there are advancements in the newer types of insulin and injection devices. There are also alternative ways to deliver insulin, and more that may appear in the near future.

With a normal pancreas, there is a small amount of "background" insulin being "pulsed" or pushed out between meals and overnight. When calories are being consumed, there is a "bolus" or squirt of insulin to allow the glucose to enter the cells. For many years, people who needed to replace insulin with injections had only four types of insulins (NPH, LENTE, ULTRALENTE, REGULAR) available. But these insulins could not properly replace the function of the pancreas. This meant people with diabetes would still have the symptoms of unstable blood sugar throughout the day and night, causing erratic control. Other problems with insulin injections include: inability to see the tiny lines on the insulin syringe barrel, air bubbles in the syringe, site selection, and lack of knowledge regarding the action of insulin. With today's newer technology, these issues should not keep people from experiencing better blood sugar control.

Since 1996, three more types of insulin have been developed. This has enabled doctors to prescribe insulin that more closely mimics how insulin is released from the pancreas. Rapid /fast acting types (LISPRO, ASPART) are given or "*bolused*" before the meal. They begin working in 10-to-15 minutes and are out of the body in 4-5 hours. These bolus insulins cover the rise in sugar from a meal. A long acting type of insulin (GLARGINE) lasts up to 24 hours, similar to the background insulin produced from the pancreas. There are mixtures of the older and newer insulins with both short/fast and long acting insulin in the same vial or cartridge. They appear as 70/30 or 75/25. This means 70% of the dose is a longer acting and 30% is faster acting.

Just as important as the new insulins are the newer injection devices that have been invented. From the original glass syringe to the disposable plastic syringe, we now have newer devices for administering insulin.

INSULIN PENS

Pens can hold up to 300 units of insulin in a cartridge. A person can dial the dose of insulin and inject through a small needle attached to the pen. These pens are metal or plastic. Some are disposable and others refillable with a cartridge of insulin. The insulin pens larger numbers and lines means decreased chance of taking the wrong dose. Some insulin pens use a display showing when the injection is complete. All pens can have the dose "dialed in". This also reduces the chance of giving the wrong dose.

INSULIN PUMPS

Pumps have been around since 1983, and are the most accurate, precise, and flexible insulin delivery system currently available. A pump is the size of a pager. It uses a battery powered pump to push insulin through a thin plastic tube just under the skin. This goes into the same area used by injections, but the soft tube stays under the skin for two to three days.
The pump continuously delivers a small amount of insulin (basal or background) 24 hours a day, very similar to a pancreas. When food is eaten, a small amount of insulin can be programmed and "bolused", matching up to the amount of carbohydrate that is being consumed. The experienced pumper can use this tool free of the strict scheduling demands required by conventional uses of insulin .

FUTURE METHODS

Don't want to consider injecting insulin in the abdomen, arm, leg, or buttocks? New ways to take insulin are being developed as you read this. Pills, patches, mouth sprays, and inhalers are in the pipeline. Don't look for these to be available soon, as the closest is a few years from being available.

INSULIN INHALERS

The insulin inhalers will work like asthma inhalers. Insulin will be breathed into the mouth and absorbed through the lungs. Insulin inhalers would only use fast acting insulin at mealtime.

MOUTH SPRAYS

Insulin mouth sprays will use an aerosol spray. The insulin will be absorbed through the inside of the cheeks and in the back of the mouth, not the lungs. Insulin mouth sprays will be available as a fast acting insulin for meals, and as a background (basal) dose.

PILLS

Currently insulin is not available in pill form. The pill must be able to pass through the digestive system without being destroyed. In the future, an insulin pill would contain special molecules that would help it pass through the gastrointestinal system intact, without the pill being broken down. These pills will have a peak action of 15 minutes, so these insulin pills will be considered fast acting for mealtimes.

PATCHES

Insulin Patches will be a 12 or 24 hour patch delivering background (basal) insulin. It would have a device that makes microscopic holes in the top layer of the skin. Then the patch will be applied, and the absorption process begins.

The goal for diabetes is to have blood sugars as near to normal as possible to decrease the chances of developing complications. Using insulin sooner than later can be beneficial to our patients' health.

LEAP TO BETTER HEALTH: EMPLOYEES SET EXAMPLE TO PREVENT DIABETES!

Submitted by: David Bolt, COO
Lewis County Primary Care Center

Lewis County Primary Care Center (LCPCC) is a federally qualified health center with clinics in Vanceburg, Tollesboro and Flemingsburg, Kentucky. The clinic has served the citizens of the area for over twenty years and continues to grow to meet changing and challenging healthcare issues. **One of these healthcare challenges includes diabetes education and prevention efforts as well as employee health as an example to the community.**

Lewis County is one of the larger counties in the state covering over 484 square miles, but its population is only 14,092, according to the 2000 Census. Complicating matters is the fact that Lewis County is one of 39 counties in the state without a hospital. Lewis Co. Primary Care Center is the provider of choice for the area.

Because of the isolation of the area, LCPCC has had to be creative over the years. Jerry Ugrin, CEO at LCPCC since 1987, has been the driving force behind many of the changes and much of the growth of the clinic. "Sometimes," Ugrin says, "when you are in situation like ours you have to be more self-reliant. You can't count on others to come to your rescue."

Ugrin has learned is to listen to employees. "The long term employees have an interest in the organization doing well," Ugrin adds. Additionally, you learn from experience. LCPCC has been involved in a national Cardiovascular Disease (CVD) Collaborative for almost two years and is currently expanding **this quality improvement/ practice change initiative to include diabetes.** As part of the Collaborative, the center has incorporated practices to help **patients with diabetes self-management goal setting.** Ugrin felt, if it is good for our patients, it might be good for employees.

It was a combination of the guiding management principle of listening to employees, along with learning from the experience of the CVD Collaborative that helped chart a course for LCPCC and set an example for the community.

In late 2003, LCPCC was confronted with an increase in the cost of health insurance for employees. It was then that Ugrin decided to open the discussion with the Patient Improvement Program (PIP) Team. PIP is an employee team that looks over everything from patient satisfaction to improvements in care for patients and staff. Ugrin was surprised and delighted at the same time with the Team's response.

"The thing that amazed me most is that the Team really took charge of the problem and developed the program that will, hopefully, reduce our employee health insurance cost and give us a healthier group of personnel," Ugrin stated.

The program the Team developed was called **L.E.A.P.**, which is an acronym for **Lifestyle Enhancement Activity Program**.

A basic premise of the program is that all employees are interested in looking, feeling and being healthy, but sometimes lack the incentive, support and assistance to begin and sustain healthy habits. LEAP provides all of these elements.

At a regularly scheduled staff meeting, the program was unveiled using an animated PowerPoint presentation. Ugrin was cast as Monty Hall from the Let's Make a Deal game show. Employees were asked if they wanted to choose to improve their individual health. And, they were told that if they set goals to improve and met those goals over a six-month period they would receive either $200 as a cash bonus, or two personal days off, with pay. Additionally, they could use the LCPCC Fitness Center for free for the duration of the program. What else could you ask for? Well, Ugrin added another carrot. If employees meet their goals at the end of the first six months, and continue to meet them the next six months, more incentives are available.

The components of the **LEAP** by which the individual employee goals will be measured are as follows:

- Blood Pressure
- BMI
- Waist to Hip Ratio
- Lipid Profile plus Glucose
- Smoking
- Exercise

A medical provider oversees the program and is assisted by a nurse. The provider evaluates employees based on the program measures and works with employees to set goals. Employees who want to set cardiovascular goals can have cardiovascular endurance, flexibility, or muscular endurance goals tested at the LCPCC Fitness Center. Laboratory tests, x-rays and the examination by the medical provider, as well as use of the Fitness Center, are free during the time of the employee's involvement in **LEAP.**

Has **LEAP** been successful? What were the organizational goals? Has there been a savings?

Of the 57 employees at LCPCC, 44 participated in the first round of L.E.A.P. The original round began October 3, 2003. The round was extended April 4, 2004 with 29 employees participating. The 29 employees were close to their goals and it was felt that they needed extra time to be successful. Of the 29 individuals, 16 accomplished their goals. They lost a combined 115 pounds, dropped an average of 37.9 points on cholesterol, 63 points on triglycerides, 34 points on LDL and showed a positive gain of 7 points on HDL levels. There were five employees in the program who smoked. Two were successful in their efforts to quit. None of those who participated in **LEAP** experienced inpatient admissions during the year. Their cost experiences for health care during the year were also lower than the previous benefit period, according to Ugrin.

The 14 employees, who met their goals, chose between paid days off and a $200 cash bonus. Most took the days off. However, it was a calculated risk. Ugrin had figured that if the program was successful in preventing, or employees reduced, inpatient services by three admissions, the project

(LEAP continued on next page)

(LEAP continued)

would pay for itself. And, since the insurance is rated on group experience, the reduction in inpatient usage and the potential of improved health status among employees may have an added benefit: stable or lower insurance rates for next year.

An interesting side benefit is that LCPCC providers and employees seem more willing to talk to patients about lifestyle changes. Some patients have even noticed changes in the appearance of certain employees and asked how they made the changes.

Long-term accomplishments will have to be measured over the next few years. Problems with the program have been keeping the enthusiasm and employees focused. Busy schedules, late night clinics and hectic family lives all seem to interfere with the process. But, LCPCC has learned that if you don't try, you will never succeed.

Ugrin feels the program will be a success whatever the outcome. "We have made the first steps and we have learned from our experiences. We may have to make some modifications, but we will continue the program. And, we will all benefit from the process."

The program is continuing and there are some changes. In August, 2004, with the new health insurance benefit period employees had a choice. They could join **LEAP**, or they would have to pay $50 per month for their health insurance. We will continue to watch the progress of the program as it continues to grow, change and provide the incentive to employees to make healthy choices.

THE COUNCIL OF STATE GOVERNMENTS PASS DIABETES RESOLUTION ON DIABETES CARE

Submitted by: Stewart Perry,
Chair National Advocacy Committee

A resolution on Diabetes Care was passed by the Council of State Government! This may be helpful to you and diabetes advocates as you speak to policy makers regarding diabetes issues (especially those that concern rollbacks of the diabetes law in KY requiring coverage for diabetes medications, supplies & education). The Resolution is as follows:

WHEREAS, 18.2 million Americans, or 6.3% of the population, live with diabetes;

WHEREAS, diabetes is the sixth leading cause of death in the United States;

WHEREAS, several states now have incidence rates of diabetes greater than 10%;

WHEREAS, about one third of Americans living with diabetes do not know that they have the disease;

WHEREAS, the total cost of diagnosed cases of diabetes in the United States is estimated as more than $130 billion annually;

WHEREAS, improperly managed diabetes often leads to costly diabetes related complications;

WHEREAS, once identified, these diabetes related complications have a tremendous impact and exact a substantial toll on state Medicaid programs;

WHEREAS, with affordable access to appropriate medications, supplies and services, patients' lives are improved by a reduced risk of diabetes related complications including a decreased risk of heart disease, lower-extremity amputation rates, fewer cases of blindness, reduced need for additional costly medical interventions, and fewer emergency room visits and hospitalizations;

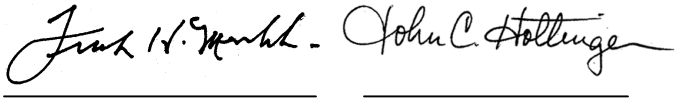
WHEREAS, numerous studies demonstrate that diabetes treatments and therapies improve diabetes control and reduce the incidence of, while significantly reducing the costs to public and private health insurance programs from, complications due to diabetes;

WHEREAS, laws enacted in forty-six states require insurers and managed care plans to cover medically necessary medications, supplies, equipment and services for people with diabetes;

BE IT NOW THEREFORE RESOLVED that The Council of State Governments encourages **all state legislators to oppose efforts to roll back, weaken or eliminate existing provisions requiring health insurers of all forms to cover necessary medications, supplies, equipment and education needed to appropriately self-manage diabetes; and**

BE IT FURTHER RESOLVED that CSG encourages those states without legal provisions enacted requiring state regulated health insurers of all forms to enact legal provisions requiring state regulated health insurers of all forms to cover necessary medications, supplies, equipment and education needed for people living with diabetes to appropriately self-manage diabetes.

Adopted this 29th Day of September 2004, at the
CSG Annual State Trends and Leadership Forum
In Anchorage, Alaska



Governor Frank Murkowski
2004 CSG President

State Senator John Hottinger
2004 CSG Chair

New Diabetes Clinical Practice Recommendations to be Published in January 2005

Watch for the Diabetes Care, January 2005, Supplement Issue, to review the newest Diabetes Clinical Practice Recommendations by the American Diabetes Association! The Guidelines can be downloaded through www.Diabetes.org/DiabetesCare or a copy can be ordered by calling 1-800-676-4065 (approximate cost of $36.00).

Kentucky Diabetes Prevention & Control Program To Release New Diabetes Burden Document

The Kentucky Diabetes Prevention & Control Program (KDPCP), through the Kentucky Department for Public Health, will soon publish a new *Diabetes in Kentucky Burden Document.* This resource was last published several years ago and has been updated with the newest Kentucky diabetes surveillance data. Watch future issues of this newsletter for further information.

Free Diabetes Resource Kit For Business and Managed Care Worksites Now Available

The National Diabetes Education Program (NDEP) is offering a *Business and Managed Care Worksite Kit* which includes a number of lesson plans addressing a wide range of diabetes-related topics such as nutrition, physical activity, general medical care, emotional well-being, and cardiovascular health. Health care professionals or wellness coordinators can present the lessons based on these plans, but knowledgeable human resource managers and supervisors may also be able to deliver the material. The lesson plans can serve as a basis for a variety of health education activities such as a lecture series on health issues, a diabetes support group, or "lunch and learn" sessions.

Each plan includes objectives, a script to guide the lesson, overhead masters, participant handouts, and suggestions for props and group activities. The lesson plans focus on diabetes issues; however, they can also be adapted for general health and wellness programs.

Each lesson plan is available in PDF format in the following categories:

General Diabetes Education
Managing Diabetes Complications
Cardiovascular Disease
Nutrition, Weight Control, and Physical Activity
Emotional Well-Being

For more information concerning this worksite kit, visit http://www.diabetesatwork.org/lessons.htm

Secretary Announces Plan to Fight Diabetes, Highlights Efforts to Promote Prevention

Article Adapted From HHS Press Release

Health and Human Services (HHS) Secretary Tommy G. Thompson has announced a national plan to fight diabetes! *Diabetes: A National Plan for Action* is a step-by-step guide of activities and resources to combat a disease that affects more than 18 million Americans.

"This action plan provides specific steps that everyone can take to fight diabetes," Secretary Thompson said. "The most effective way to bring this problem under control is for government, business, health care providers, schools, communities, the media, and people effected by diabetes to work together."

The diabetes action plan focuses on specific, attainable action steps. For instance, goals for individuals include reducing fat consumption, taking the stairs instead of the elevator, and getting screened for diabetes. Businesses can provide healthy food in vending machines and cafeterias, and turn conference space into exercise rooms. Civic groups can create community gardens and install distance markers on sidewalks to encourage walking for health. Government agencies can develop evidence-based strategies to prevent, detect and treat diabetes as well as programs to implement them, such as Medicare coverage for diabetes screening (which takes effect January 1, 2005).

Secretary Thompson convened town hall meetings in Cincinnati, Little Rock, and Seattle over the last year to hear how diabetes is impacting communities and the steps being taken to reverse this trend. Individuals with diabetes, health care providers, members of the business community, and others provided input that culminated in this national diabetes action plan.

The entire document is 87 pages long and may be useful to diabetes educators and advocates.
This document may be downloaded at http://aspe.hhs.gov/health/NDAP/NDAP04.pdf

DIABETES DAY AT THE CAPITOL PLANNED FOR FEBRUARY!!

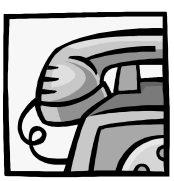
The KY Diabetes Network (KDN) and partners are planning a

Diabetes Day at the Capitol!

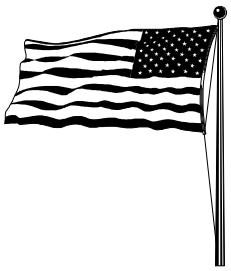
This event will be held Tuesday, February 8th, 2005, in Frankfort, KY. Participants will meet with legislators to educate them about the burden of diabetes with the **goal of increasing KY diabetes funding.**

A training session will be held in the morning prior to individual legislative meetings.

If you would like information or would like to participate, contact:



Deborah Fillman
270-686-7747 ext. 5581
deborah.fillman@grdhd.org



RECEIVE FREE BOOK "MEDITATIONS ON DIABETES"

GlaxoSmithKline is offering a free book for diabetes educators, *Meditations on Diabetes,* by Catherine Feste. This book applies life principles and philosophies to coping with the day-to-day challenges of living with diabetes. Claim your FREE book by calling 1-800-345-1809.

DECA DIABETES EDUCATOR MEETINGS SCHEDULED

Diabetes Educators of the Cincinnati Area (DECA), which covers Northern KY, meets the third Monday of each month (September through April) from 5:30 – 7:30 pm.
Meetings are usually held at Good Samaritan Hospital in Cincinnati, Ohio; however location may vary. The planned meetings include:

- 2-21-05 Stress and Humor
- 3-21-05 Polycystic Ovarian Syndrome (PCOS)
- 4-18-05 Exercise and Diabetes

Anyone interested in diabetes is invited. Please register with Mary Ann Benzing 513-248-9992.

GLADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Greater Louisville Association of Diabetes Educators (GLADE), which covers Louisville and the surrounding area, meets the 2nd Tuesday of the month from 5:30 – 7:30 pm *(no meeting in July or August).* There is no cost unless CEU's are provided. If continuing education is provided, the cost will be $5.00 for non-GLADE members. For a schedule or more information, contact GLADE President, Kim Jackson at 502-574-6663 or kimberly.jackson@loukymetro.org

GREATER LOUISVILLE ASSOCIATION OF DIABETES EDUCATORS 20TH ANNIVERSARY!

GLADE IS 20 YEARS OLD THIS YEAR!

CONGRATULATIONS AND HAPPY ANNIVERSARY TO YOU ALL!

KADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Kentucky Association of Diabetes Educators (KADE), which covers Lexington and Central Kentucky, meets the 3rd Tuesday of every month except summer (time & location vary). For a schedule or more information, contact:

Karen McKnight
Phone: 859-313-4282
E-mail: mcknighk@chimail.sjhlex.org
or
Laura Hieronymus
Phone: 859-223-4074
laurahieronymus@cs.com

TRADE DIABETES EDUCATOR MEETINGS SCHEDULED

The Tri-State Association of Diabetes Educators (TRADE), which covers Western KY/Southern IN, meets quarterly from 11 – 2 pm CST with complimentary lunch and continuing education units. The planned meetings includes:

Date:	**Thursday, January 20, 2005**
Title:	Hyperglycemia In The Hospitalized Patient
Speaker:	Sri Prakash L. Mokshagundam Associate Professor, Division of Endocrinology & Metabolism University of Louisville
Location:	HealthPark 1006 Ford Avenue Owensboro, KY
Date:	**Thursday, April 21, 2005**
Title:	Diabetes & Osteoporosis
Speaker:	Zouhair Bibi, MD
Location:	Lorenzo's Bistro & Bakery Restaurant 976 S Hebron Ave. Evansville, IN
Date:	**Thursday, July 21, 2005**
Title:	*TBA*
Speaker:	Vasdev Lahano, MD, FACE
Location:	Salem United Church of Christ 202 East Fourth Street Huntingburg, IN

ENDOCRINOLOGISTS MEETINGS SCHEDULED

The Ohio Valley Chapter of the American Association of Clinical Endocrinologists (AACE) and the Kentuckiana Endocrine Club meet on a regular basis. For a schedule of meetings, contact:

Dr. Vasti Broadstone
Phone: 812-949-5700
E-mail: joslin@EMHHS.com

Kentucky Diabetes Connection

Contact Information

American Diabetes Association.
Cure • Care • Commitment

www.diabetes.org
1-888-DIABETES

TRADE
Tri-State Association of Diabetes Educators

www.aadenet.org/
AboutAADE/Chapters.html

KDN
KENTUCKY DIABETES NETWORK, INC.

www.kentuckydiabetes.net

KENTUCKY ASSOCIATION of DIABETES EDUCATORS
KADE
Bluegrass/Eastern Chapter

www.kadenet.org

GREATER LOUISVILLE ASSOCIATION OF DIABETES EDUCATORS
GLADE 1984

www.louisvillediabetes.org

KENTUCKY DIABETES PREVENTION AND CONTROL PROGRAM
KDPCP

www.chs.ky.gov/publichealth/
diabetes.htm

JDRF Juvenile Diabetes Research Foundation International
dedicated to finding a cure

www.jdrf.org/chapters/
KY/Kentuckiana
1-866-485-9397

DE CINCINNATI A
Diabetes Educators Cincinnati Area

www.aadenet.org/
AboutAADE/Chapters.html

AACE American Association of Clinical Endocrinologists
Ohio Valley Chapter

www.aace.com

Kentuckiana Endocrine Club
Joslin@EMHHS.com